Health Information Request to Release Records

Patient Name: _____

DOC ID/AO Number: _____ Date of Birth: _____

Social Security Number: _____

1. I authorize the use or disclosure of the above named individual's health information as described below:
2. All health care information in your possession, whether generated by you or by any other source, may be released to me or to _____[name person] for:

_____
_____[purpose of the disclosure].

3. Covering the period(s) of healthcare:
   From (date) _____ to (date) _____
   From (date) _____ to (date) _____
4. Information to be disclosed:

☐ Discharge Summary	☐ Progress Notes	☐ Operative Notes
☐ History & Physical	☐ Laboratory Tests	☐ Pathology Report
☐ Consultation Reports	☐ Emergency Room Report	☐ X-ray/imaging Reports
☐ Immunization Record	☐ Complete Health Record	

☐ Other (please specify)_____

5. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or Hepatitis A, B or C. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

6.The revocation is effective from the time it is communicated to the health care provider, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization is valid for up to 30 months from the date of execution below. If no expiration is specified this authorization will automatically expire six (6) months from the date of signing. This authorization does not permit the release of health care information relating to health care that the patient receives more than 6 months from the date of execution below. Mont. Code Ann. §50-16-527.

7. The Montana Department of Corrections, its health care providers, employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information pursuant to the Uniform Health Care Information Act, Mont. Code Ann. §50-16-501 through §50-16-553 or the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. 1320d..

8. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of patient or patient's representative Date

_____
Relationship to the patient

_____ _____
Witness Date

*This authorization is valid for up to 30 months from the date above.

NOTE: This form is pursuant to *DOC Policy 4.5.38; Offender Health Record Access, Release, and Retention, DOC Policy 1.5.5, Offender Records Management, Access and Release,*